

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

6678

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Russ Primary Registration District No. 1002  
 City Kansas City, Mo (No. Research / Bus)  
 File No. \_\_\_\_\_ Registered No. 8413 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Harold Heisterberg  
 (a) Residence No. Cole Camp, Mo St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 - 1914

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
14 2 2

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work School Boy  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cole Camp (STATE OR COUNTRY) Mo

10. NAME OF FATHER R. J. Heisterberg

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cole Camp (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Haggie Hallman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cole Camp (STATE OR COUNTRY) Mo

14. INFORMANT R. J. Heisterberg (Address) Cole Camp, Mo

15. 2-20-29 M M Traver REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19 - 1929

17. I HEREBY CERTIFY That I attended deceased from February 13, 1929 to February 19, 1929 that I last saw him alive on February 19, 1929, and that death occurred, on the date stated above, at 2:57 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Brain tumor, Glioma of cerebellum  
5.00 (duration) 1 yrs.  mos.  ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Cole Camp, Mo  
 IF NOT AT PLACE OF DEATH...  
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb. 19, 1929  
 WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONFIRMED DIAGNOSIS? operation + autopsy  
 (Signed) Frank Koleschenos M. D.  
Feb. 20, 1929 (Address) 1007 Argyle Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Way Mo DATE OF BURIAL Feb 20 - 1929

20. UNDERTAKER John W Wagner ADDRESS 1409 Grand Ave

2444

10.12.1944

1.12.1944

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399 File No. ....  
 Township..... Primary Registration District No. 1002 Registered No. 843  
 City K. City (No. ....) St. .... Ward)

**2. FULL NAME**

Harold Heisterberg  
 (a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 - 1914

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work.....
- (b) General nature of industry, business, or establishment in which employed (or employer).....
- (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

**PARENTS**

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED 3/20, 1929 M. M. Crowe REGISTRAR  
Assn

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19 1929

17. I HEREBY CERTIFY That I attended deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Brain tumor  
Diagnosis (malignant)  
 (duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)\*

(duration)..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. Rechenow, M. D.

Nov 21, 1929 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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